

Bureau of Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS2725AGC</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/21/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>AGAPE LOVE FACILITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1211 NORTH H STREET LAS VEGAS, NV 89106</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
Y 000	<p><b>Initial Comments</b></p> <p>This Statement of Deficiencies was generated as a result of the annual state licensure survey conducted at your facility on 10/21/08.</p> <p>The survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006.</p> <p>The facility was licensed for 4 total beds.</p> <p>The facility had the following category of classified beds: Category 1- 4 beds</p> <p>The facility had the following endorsements: Residential facility which provides care to elderly and/or disabled persons, and /or persons with mental illness.</p> <p>The census at the time of the survey was 2. Two resident files were reviewed and 1 employee files was reviewed.</p> <p>There were no complaint(s) investigated during the survey.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>The following regulatory deficiencies were identified:</p>	Y 000	<p><b>RECEIVED</b> <b>FEB 23 2009</b> BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA</p> <p><i>Acceptable POC Attachment of 4/7/09 Deegul</i></p>		
Y 051 SS=D	449.194(2) Administrator's Responsibilities-Designation	Y 051			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
<i>Emma Love Director</i>		<i>2-23-09</i>
STATE FORM 6899	H10811	If continuation sheet 1 of 18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS2725AGC</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/21/2008</b>
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Y 051	449.194(2) Administrator's Responsibilities-Designation	Y 051			

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(X6) DATE

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STATE FORM

6899

H10811

If continuation sheet 1 of 18

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Y 051	<p>Continued From page 1</p> <p>NAC 449.194 The administrator of a residential facility shall:</p> <p>2. Designate one or more employees to be in charge of the facility during those times when the administrator is absent. Except as otherwise provided in this subsection, employees designated to be in charge of the facility when the administrator is absent must have access to all areas of and records kept at the facility. Confidential information may be removed from the files to which the employees in charge of the facility have access if the confidential information is maintained by the administrator. The administrator or an employee who is designated to be in charge of the facility pursuant to this subsection shall be present at the facility at all times. The name of the employee in charge of the facility pursuant to this subsection must be posted in a public place within the facility during all times that the employee is in charge.</p> <p>This Regulation is not met as evidenced by: Based on observation and interview, the administrator failed to designate one or more employees to be in charge of the facility during those times when the administrator was absent.</p> <p>Findings include:</p> <p>On arrival to the facility, Employee #2 was unable to provide the employee files for 3 of the employees.</p> <p>During facility tour, there was no documented evidence seen as to who was in charge of the facility when the administrator was absent. Employee #2 was unable to open the lower locked drawer in the file cabinet.</p>	Y 051	<p><b>RECEIVED</b> <b>FEB 23 2009</b> BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA</p> <p>Y051 Corrected 10/22/08 Files were presented the following day.</p> <p>In the absent of the Administrator the staff member on duty will be designated as in charge of the facility and have access to all file cabinets according to 449.194</p> <p>Monitoring will be conducted on a weekly basis (randomly) by the Administrator.</p> <p>Confidential information will be removed and kept by the Administrator.</p>	

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10/21/2008

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Y 051	<p>Continued From page 2</p> <p>On 10/21/08 at 8:30am, Employee #1 (Administrator) revealed per phone conversation she was in court and would bring any information needed to the Bureau of Licensure and Certification office the next day.</p> <p>Employee #1 provided the requested documentation on 10-24-08. Employee #1 revealed the employee records were not available due to a past incident of identity theft. Employee #1 stated a coordinator at Southern Nevada Adult Mental Health Services told Employee #1 to keep the files locked.</p> <p>Severity: 2      Scope: 1</p>	Y 051	<p><b>RECEIVED</b></p> <p><b>FEB 23 2009</b></p> <p>BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA</p>	
Y 105	<p>449.200(1)(f) Personnel File - Background Check</p> <p>NAC 449.200</p> <p>1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include:</p> <p>(f) Evidence of compliance with NRS 449.176 to 449.185, inclusive.</p> <p>This Regulation is not met as evidenced by: Based on record review, the facility failed to ensure that 3 of 4 employees had met the background check requirements for criminal history.</p> <p>Findings include:</p> <p>Employee #1 was hired on 11-22-98. The personnel file did not contain a signed statement indicating the employee had not been convicted of any crimes listed in NRS 449.188.</p>	Y 105	<p>Y105 Corrected. 10/22/08 Background Check statement have been signed by Employees #1, #2, #3 and placed in prospective files.</p> <p>Monthly monitoring of files will be conducted by the Administrator.</p>	

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Y 105	Continued From page 3  Employee #2 was hired on 7-27-07. The personnel file did not contain a signed statement indicating the employee had not been convicted of any crimes listed in NRS 449.188.  Employee #3 was hired on 10-01-02. The personnel file did not contain a signed statement indicating the employee had not been convicted of any crimes listed in NRS 449.188.  There was no evidence in the employee file regarding an updated background check report.  Severity: 2                      Scope: 3  This is a repeat deficiency from survey of 8-01-07.	Y 105	<div style="text-align: center;"> <p>RECEIVED</p> <p>FEB 23 2009</p> <p>BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA</p> </div>		
Y 108	449.200(3) Per File - Storage & Availability  NAC 449. 200 3. The administrator may keep the personnel files for the facility in a locked cabinet and may, except as otherwise provided in this subsection, restrict access to this cabinet by other employees of the facility. Copies of the documents which are evidence that an employee has been certified to perform first aid and cardiopulmonary resuscitation and that the employee has been tested for tuberculosis must be available for review at all times. The administrator shall make the personnel files available for inspection by the bureau within 72 hours after the bureau	Y 108			

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Y 108	<p>Continued From page 4</p> <p>requests to review the files.</p> <p>This Regulation is not met as evidenced by: Based on record review and staff interview, the administrator failed to ensure employee files would be accessed for immediate review.</p> <p>Findings include:</p> <p>On arrival to the facility, Employee #2 was unable to provide the employee files for 3 of the employees (Employee #1, Employee #3 and Employee #4). Employee #2 was unable to open the lower locked drawer in the file cabinet.</p> <p>On 10/21/08 at 8:30am, Employee #1 (Administrator) revealed per phone conversation she was in court and would have to bring any information needed to the Bureau of Licensure and Certification office the next day.</p> <p>Employee #1 provided the requested information from the survey. Employee #1 revealed the employee records were not available due to a past incident of identity theft. Employee #1 stated a coordinator at Southern Nevada Adult Mental Health Services told Employee #1 to keep the files locked.</p> <p>Employee files for Employee #1 (Administrator), Employee #3 and Employee #4 were not available for immediate review upon request during the survey. The Administrator stated the employee files were kept locked in the bottom drawer of the file cabinet when she was not in the</p>	Y 108	<div>RECEIVED</div> <div>FEB 23 2009</div> <div>BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA</div>		

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Y 108	Continued From page 5  facility. Proof that employees had completed cardiopulmonary resuscitation and first aid training and proof of tuberculosis testing was not available for immediate review.  Severity: 2 Scope: 3	Y 108		
Y 175	449.209(4)(b) Health and Sanitation-Hazards  NAC 449.209 4. To the extent practicable, the premises of the facility must be kept free from: (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility.  This Regulation is not met as evidenced by: Based on observation and interview, the facility failed to maintain the facility free from hazards.  Findings include:  Upon entering the dining room of the facility at 8:15AM, 2 floor tiles were noticed to be missing (approximately 1 square foot each) on the dining room floor. One tile was missing as at the entrance to the dining room and the other tile was missing near the side door of the dining room. Both areas on the floor were rough in appearance.  The uncovered wooden walkway located outside the house leading to the laundry room was not properly supported and sagged when walking on it. The door to the laundry room was off the hinges and had to be moved to gain access to the laundry room. There was approximately a 6 inch hole in the laundry room floor to the right of the doorway.	Y 175	<p><b>RECEIVED</b> <b>FEB 23 2009</b> BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA</p> <p>Y175 Corrected 11/16/008 Bedroom #1 and #2 closet doors have been repaired. Hallway closet door have been replaced. Laundry Room door, walls have been repaired and hole filled.</p> <p>Upon each shift, staff will be responsible for facility inspection and report all infractions to Administrator</p> <p>Administrator will monitor facility bi-weekly for all Health and Sanitation Hazards</p>	

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NY 725AGC

A. BUILDING

B. WING

10/21/2008

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Y 175	<p>Continued From page 6</p> <p>The Residents have free access to this wooden walkway.</p> <p>During initial facility tour, it was observed the closet doors in bedroom #1 and bedroom #2 were off the track. One of the doors on the hall closet had been removed.</p> <p>Employee #2 stated the administrator was to have someone come to the facility today to give an estimate for repair to dining room, walkway and laundry room door. Employee #2 indicated residents do not walk on the walkway at this time.</p> <p>Employee #2 revealed the residents occupying bedroom #1 and bedroom #2 would break the closet doors when they would get upset. This had been a recurrent problem.</p> <p>Employee #2 indicated the door to the hall closet was being repaired. There was no date indicated as to when it would be replaced.</p> <p>The Administrator revealed she planned to have an estimate done for cost of repairs to the walkway, the laundry room door and the tiles on the dining room floor. The administrator revealed she would have the estimate done within the next 10 days.</p> <p>Severity: 2 Scope: 3</p>	Y 175	<p><b>RECEIVED</b></p> <p><b>FEB 23 2009</b></p> <p>BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA</p>	
Y 453	<p>449.231(2)(c) First Aid Kit</p> <p>NAC 449.231 2. A first-aid kit must be available at the facility.</p>	Y 453		

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## Bureau of Licensure and Certification

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Y 453	Continued From page 7  The first-aid kit must include, without limitation: (c) Adhesive bandages, rolls of gauze and adhesive tape.  This Regulation is not met as evidenced by: Based on observation, the facility failed to provide a complete first aid kit.  Findings include:  There were no rolls of gauze within the first aid kit.  Severity: 1    Scope: 3	Y 453	Y453 Corrected 10/22/08 First Aid Kit have been replaced and included the required materials.  Staff will inspect the beginning of each shift and monitored weekly by the Administrator.  <b>RECEIVED FEB 23 2009 BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA</b>	
Y 455	449.231(2)(e) First Aid Kit - CPR Mask  NAC 449.231 2. A first-aid kit must be available at the facility. The first-aid kit must include, without limitation: (e) A shield or mask to be used by a person who is administering cardiopulmonary resuscitation.  This Regulation is not met as evidenced by: Based on observation, the facility failed to provide a complete first aid kit.  Findings include:  There was no evidence of a shield or mask for CPR in the first aid kit.  Severity: 1    Scope: 3	Y 455	Y455 Corrected 10/22/08 First Aid Kit includes CPR face masks and shields.  Staff will inspect the beginning of each shift and monitored weekly by the Administrator.	

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If continuation sheet 8 of 1.

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA  
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NVS2725AGC

(X2) MULTIPLE CONSTRUCTION

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(X3) DATE SURVEY  
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Y 456	Continued From page 8	Y 456		
Y 456	449.231(2)(f) First Aid Kit  NAC 449.231 2. A first-aid kit must be available at the facility. The first-aid kit must include, without limitation: (f) A thermometer or other device that may be used to determine the bodily temperature of a person.  This Regulation is not met as evidenced by: Based on observation, the facility failed to provide a complete first aid kit.  Findings include:  There was no evidence of a thermometer found in the first aid kit. Employee #2 was unable to produce a thermometer.  Severity: 1      Scope: 3	Y 456	Y456 Corrected 10/22/008 First Aid Kit includes a thermometer.  Staff will inspect the beginning of each shift and monitored weekly by the Administ trator.	
Y 870	449.2742(1)(a)(1) 449.2742(1)(a)(1) Medication Administration  NAC 449.2742 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary	Y 870		

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BUREAU OF LICENSURE AND CERTIFICATION  
LAS VEGAS, NEVADAIf deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.  
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Y 870	<p>Continued From page 9</p> <p>supplements taken by a resident.</p> <p> </p> <p>This Regulation is not met as evidenced by: Based on record review, the facility failed to ensure a medication profile review was performed by a physician, pharmacist or registered nurse at least once every six months for 2 of 2 residents residing in the facility for longer than six months (Resident #1 and #2).</p> <p>Findings include:</p> <p>Resident #1 was admitted to the facility on 6-26-01. The last medication profile review available in the record was dated 12-6-07.</p> <p>Resident #2 was admitted to the facility on 10-13-06. The last medication profile review available in the record was dated 12-4-07.</p> <p>Severity: 2 Scope: 3</p>	Y 870	<div style="text-align: right;"> RECEIVED  FEB 23 2009  <small>BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA</small> </div> <p>Y870 Corrected 10/22/08 Medication profile will be reviewed every 6 months by a physician, pharmacist or registered nurse of non interest in the facility.</p> <p>The Administrator will be the responsible party to insure review.</p>	
Y 883	<p>449.2742(7) Medication / Resident Refusal</p> <p> </p> <p>NAC 449.2742 7. If a resident refuses, or otherwise misses, and administration of medication, a physician must be notified within 12 hours after the dose is refused or missed.</p> <p> </p> <p>This Regulation is not met as evidenced by:</p>	Y 883		

Bureau of Licensure and Certification

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(X2) MULTIPLE CONSTRUCTION

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(X4) ID  
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DEFICIENCY)

(X5)  
COMPLETE  
DATE

Y 883

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Based on interview and record review, the facility failed to ensure the physician was notified when 1 of 2 residents refused to take the ordered medication (Resident #2).

Findings include:

Resident #2 was admitted on 10-13-06. Albuterol 90 micrograms (mcg), 2 puffs was to be given 4 times daily. There were no caregiver initials placed on the medication administration record (MAR) by Albuterol for the past 5 months (June 2008 through October 2008). There was no copy of a prescription in the resident record. There was no notation the resident refused to take the medication.

Employee #2 indicated Resident #2 refused to use the Albuterol inhaler. Employee #2 revealed she did not know the physician needed to be notified and the refusal needed to be documented on the MAR.

Severity: 2 Scope: 1

Y 897

449.2744(1)(b)(3) Medication / MAR

NAC 449.2744

1. The administrator of a residential facility that provides assistance to residents in the administration of medication shall maintain:  
(b) A record of the medication administered to each resident. The record must include:  
(3) The date and time that a resident refuses, or otherwise misses, an administration of medication.

Y 883

Y883 Corrected 10/22/08  
Staff has reviewed procedure and shall notify Administrator immediately upon resident refusal or missed medication that a physician is notified within 12 hours of occurrence.

Staff and Administrator will verify prescriptions are on file and document all administered medication(s), refusal of, or missed doses.

Staff will be monitored daily by Administrator.

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Y 897

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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H10811

If continuation sheet 11 of 11

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

NVS2725AGC

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

(X3) DATE SURVEY  
COMPLETED

10/21/2008

NAME OF PROVIDER OR SUPPLIER

AGAPE LOVE FACILITY

STREET ADDRESS, CITY, STATE, ZIP CODE

1211 NORTH H STREET  
LAS VEGAS, NV 89106(X4) ID  
PREFIX  
TAGSUMMARY STATEMENT OF DEFICIENCIES  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL  
REGULATORY OR LSC IDENTIFYING INFORMATION)ID  
PREFIX  
TAGPROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE  
CROSS-REFERENCED TO THE APPROPRIATE  
DEFICIENCY)(X5)  
COMPLETE  
DATE

Y 897 Continued From page 11

This Regulation is not met as evidenced by:  
Based on interview and record review, the facility  
failed to document resident refusal of a  
medication for 1 of 2 residents (Resident #2).

## Findings include:

Resident #2 was admitted on 10-13-06. Albuterol  
90 micrograms (mcg), 2 puffs was to be given 4  
times daily. There are no caregiver initials  
placed on the medication administration record  
(MAR) by Albuterol for the past 5 months (June  
2008 through October 2008).

Employee #2 was hired on 7-27-07. Employee  
#2 indicated Resident #2 refuses to use the  
Albuterol inhaler. Employee #2 revealed she did  
not know the physician needed to be notified and  
the refusal needed to be documented on the  
MAR.

Severity: 2 Scope: 1

Y 898 449.2744(1)(b)(4) Medication / MAR

## NAC 449.2744

1. The administrator of a residential facility that  
provides assistance to residents in the  
administration of medication shall maintain:

(b) A record of the medication administered to  
each resident. The record must include:

(4) Instructions for administering the  
medication to the resident that reflect the current  
order or prescription of the resident's physician.

Y 897

Y 898

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Y897 Corrected 1/09/09  
Staff #2 has taken refresher  
class of medical management  
on 2/12/09. Staff #2 have been  
reprimanded that upon another  
occurrence will warrant  
dismissal.

Staff will properly document  
the administering of  
medication for each resident  
with date and time  
administered, refusal or  
missed.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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## Bureau of Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS2725AGC</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/21/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>AGAPE LOVE FACILITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1211 NORTH H STREET LAS VEGAS, NV 89106</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 898	Continued From page 12  This Regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure medication administered reflects the current order of the residents physician in 2 of 2 residents (Resident #1 and #2).  Findings include:  1. Resident #1 was admitted to the facility on 6-26-01. The pharmacy label on the Fiber-Lax bottle indicated 2 tablets were to be given at breakfast and dinner.  The Medication Administration Record (MAR) was written to give Fiber Lax 1 tablet at 8am and 8pm. The MARs reviewed (June 2008 through October 2008) all were written to provide 1 tablet at 8am and 8pm. There was no documented evidence of the original physician order.  Employee #2 was not aware the Fiber Lax was not being given as ordered by the physician.  Resident #1 was ordered Seroquel 300 milligrams (mg), take 2 at bedtime. Seroquel was not indicated on the October MAR. The bottle of Seroquel was filled on 9/23/08. Employee #2 counted the remaining pills. There were 18 pills left in the bottle.  Employee #2 revealed Resident #1 had been receiving the Seroquel and was not sure why the Seroquel was not written on the MAR.  2. Resident #2 was admitted to the facility on 10-13-06. The pharmacy label on the DDAVP indicated 0.2 mg tablets, take 2 tablets at bedtime. The MAR for June 2008, July 2008,	Y 898	<p><b>RECEIVED</b> <b>FEB 23 2009</b> BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA</p> <p>Y898 Corrected 2/12/09 Staff #2, #3 and #4 have retaken Medical Management Class on 2/12/09.</p> <p>Administrator have reviewed and corrected records of the medication administered to each resident.</p> <p>Staff have been reprimanded and advised on next occurrence will warrant dismissal.</p>	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

If continuation sheet 13 of 18

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  NVS2725AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/21/2008
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NAME OF PROVIDER OR SUPPLIER  AGAPE LOVE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1211 NORTH H STREET LAS VEGAS, NV 89106
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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Y 898 Continued From page 13  
August 2008, September 2008 and October 2008 indicated the dosage was 2mg.  
  
Employee #2 was shown the medication bottle and the MAR. Employee #2 was not aware there was a discrepancy between the written dose and ordered dose of the DDAVP. This was a transcription error.

Severity: 2 Scope: 3

Y 899 449.2744(2) Medication Administration

NAC 449.2744  
2. The administrator of the facility shall keep a log of caregivers assigned to administer medications that indicates the shifts during which each caregiver was responsible for assisting in the administration of medication to a resident. This requirement may be met by including on a resident's medication sheet an indication of who assisted the resident in the administration of the medication, if the caregiver can be identified from this indication.

This Regulation is not met as evidenced by:  
Based on record review, the facility failed to ensure evidence of caregiver signatures on the Medication Administration Record (MAR) to document resident medication assistance for 2 of 2 residents (Resident #1 and #2).

Findings include:

Y 898

Y 899

Y899 Corrected 1/09/09  
Staff has retaken Medical Management Class on 2/12/09.

Staff have been advised and reprimanded on medication log and signature. Next occurrence will warrant dismissal.

Administrator will monitor log daily.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS2725AGC</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/21/2008</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 899	Continued From page 14  Resident #1 was admitted to the facility on 6-26-01. There was no documented evidence of a signature of the employee who administered the medication on the MAR for the months of June 2008, July 2008, August 2008, September 2008 and October 2008.  Resident #2 was admitted to the facility on 10-13-06. There was no documented evidence of a signature of the employee who administered the medication on the MAR for the months of June 2008, July 2008, August 2008, September 2008 and October 2008.  Severity: 1 Scope: 3		Y 899	<div style="text-align: center;"> <b>RECEIVED</b>  <b>FEB 23 2009</b>  <small>—BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA</small> </div>	
Y 938	449.2749(1)(g)(1) Resident file  NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (g) An evaluation of the resident's ability to perform the activities of daily living and a brief description of any assistance he needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident.		Y 938		Y938 Corrected 10/22/08 ADL assessment have been performed on all residents and placed in their files.  The Administrator is responsible for maintaining and monitoring of files.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS2725AGC</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/21/2008</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 938	Continued From page 15  This Regulation is not met as evidenced by: Based on record review, the facility failed to perform an evaluation on 1 of 2 residents for their abilities to perform the activities of daily living (ADL) upon admission to the facility (Resident #2).  Findings include:  Resident #2 was admitted to the facility on 10-13-06. The resident's file did not contain an ADL assessment upon admission to the facility.  Severity: 2 Scope: 1		Y 938	<div style="text-align: center;"> <b>RECEIVED</b>  <b>FEB 23 2009</b>  <small>BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA</small> </div>	
Y 940	449.2749(1)(g)(3) Resident file  NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (g) An evaluation of the resident's ability to perform the activities of daily living and a brief description of any assistance he needs to perform those activities. The facility shall prepare such an evaluation: (3) In any event, not less than once each year.		Y 940		Y940 Corrected 10/22/08 Annual evaluations of the ADL have been placed in residents file.  The Administrator and Staff #4 are responsible parties for maintaining and retention of files for at least 5 years.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS2725AGC</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/21/2008</b>
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**AGAPE LOVE FACILITY****1211 NORTH H STREET  
LAS VEGAS, NV 89106**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 940	Continued From page 16  This Regulation is not met as evidenced by: Based on record review, the facility failed to perform an annual evaluation of a resident's ability to perform the activities of daily living on 2 of 2 residents residing in the facility longer than a year.  Findings include:  Resident #1 was admitted to the facility on 6-26-01. The resident's file did not contain an annual evaluation of the resident's ability to perform the activities of daily living for 2008.  Resident #2 was admitted to the facility on 10-13-06. The resident's file did not contain an annual evaluation of the resident's ability to perform the activities of daily living for 2008.  Severity: 2 Scope: 3	Y 940		
Y 941	449.2749(1)(h) Resident file  NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (h) A list of the rules for the facility that is signed	Y 941		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS2725AGC</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/21/2008</b>
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Y 941	<p>Continued From page 17</p> <p>by the administrator of the facility and the resident or a representative of the resident.</p> <p>This Regulation is not met as evidenced by: Based on record review, the facility failed to have the rules of the facility signed by the administrator of the facility and/or the resident for 1 of 2 records reviewed (Resident #2).</p> <p>Record Review</p> <p>Resident #2 was admitted to the facility on 10-13-06. Review of the medical records on Resident #2 failed to provide evidence the rules of the facility were signed by the administrator of the facility and the resident.</p> <p>Severity: 1    Scope: 1</p>	Y 941	<p><b>RECEIVED</b> <b>FEB 23 2009</b> BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA</p> <p>Y941 Corrected 1/09/09. Separate files are to be kept on residents for at least 5 years in a locked place and against any destruction</p> <p>Administrator and resideent has signed the rules of the faacility and in files.</p> <p>The Administrator and Staff #4 are responsible parties fr maintaining and retention of files for at least 5 years.</p>		

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